

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09795  
Reg. Dist. No. 351

1. PLACE OF DEATH: Worcester  
County Snow Hill  
City or town (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 31 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Arthur Blake

3. (b) Social Security Number

215-16-3153

4. Sex Male 5. Color or race balan 6. (a) Single, married, widowed, or divorced widowed  
6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr) Aug-22-1897 (?) 6. (c) If alive, give age (?) years

8. AGE: Years 51 Months 0 Days 28 If less than one day, hrs 0 min 0

9. Birthplace Snow Hill Worcester md  
(Town, county, and state)

10. Usual occupation Salor

11. Industry or business Saw mill

12. Name Noah Blakey

13. Birthplace Maryland

14. Maiden name unknown

15. Birthplace "

16. Informant Mr Oscar K. Blakey

Address Snow Hill, Md

17. Burial Burial Date thereof Sept 22/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baptist

Location Snow Hill, Md

18. Funeral director Elmer E. Dumas

Address Snow Hill, Md

19. 9/22/48 19 48 Re Roy Smith  
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Worcester  
City or town Snow Hill  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Walden I  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 19 48 at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 45 to Sept 20 19 48  
and that I last saw him alive on Sept 20 19 48

Immediate cause of death Rupture of the aorta DURATION 1 hr.

Due to Inoperable squamous cell carcinoma of the Esophagus 2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Inoperable squamous cell carcinoma of the Esophagus Date of op. May 1948  
at Ft. Howard Veterans Hospital  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert L. La Mar, MD M. D. or other

Address Snow Hill Date signed 9-22-48

RECEIVED

SEP 25 1948

BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09796

Reg. Dist. No. 355

### 1. PLACE OF DEATH:

County Worcester  
 City or town Berlin RFD  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Worcester  
 City or town Berlin RFD  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

### 3.(a) FULL NAME

KATE GIBBS HALL

### 3.(b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow  
 6.(b) Name of husband or wife Nathan C Hall  
 6.(c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) June 17, 1877  
 8. AGE: Years 71 Months 3 Days 1 If less than one day hrs. min.

9. Birthplace Berlin Woc. Md.  
 (Town, county, and state)

10. Usual occupation Housewife

### 11. Industry or business

12. Name John D. Hibbs  
 13. Birthplace Berlin Md.  
 14. Maiden name Sally Powell  
 15. Birthplace md.

16. Informant Mr. Howard Hall  
 Address Berlin Md. RFD

17. Burial Date thereof 9/22/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin Md

18. Funeral director Bruce A. Buehge

Address Berlin Md

19. 9-20- 1948 Helen F. Hayward  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept 18 1948 at 8:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from md 1947 to Sept 1948  
 and that I last saw him alive on Sept 17 1948

Immediate cause of death Acute stenosis DURATION 5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

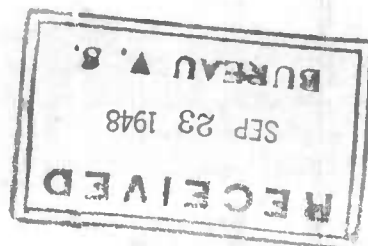
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Nathaniel K. Thomas M. D. or other

Address Ocean City, Md Date signed 19 Sept 48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH: *Worcester*  
County *More Hill*  
City or town *87 years*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State *Maryland* County *Worcester*  
City or town *More Hill*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *70*  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME *Loelia A. Henman*

3. (b) Social Security Number *None*

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*  
6. (b) Name of husband or wife *Thomas J. Henman*  
6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) *Dec 25 - 1860*

8. AGE: Years *87* Months *8* Days *21* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *More Hill Worcester MD*  
(Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *Own home*

12. Name *John C. Henman*

13. Birthplace *Maryland*

14. Maiden name *Annie Robinson*

15. Birthplace *Maryland*

16. Informant *Miss Mimi C. Henman*

Address *More Hill, MD*

17. *Burial* Date thereof *Sept 19/48*  
(Burial, cremation, or removal, When?) (month) (day) (year)

Cemetery or crematory *Whitcomb*

Location *More Hill, MD*

18. Funeral director *Elmer E. Dwyer*

Address *More Hill, MD*

19. *9/8* *19* *48* *Robert Smith*  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
20. DATE OF DEATH *September 16* 19 *48* at *12:45* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *April 15* 19 *48* to *Sept 16* 19 *48*  
and that I last saw her alive on *Sept 15* 19 *48*

Immediate cause of death *Acute Pulmonary Edema* DURATION *2 days*

Due to *Chronic Congestive Cardiac* *3 yrs*

Due to *degenerative Cardiovascular* *10 yrs*

Other conditions *Renal disease*

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

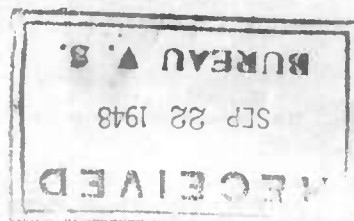
23. SIGNATURE *Robert H. La Mar, MD* M. D. or other \_\_\_\_\_

Address *More Hill* Date signed *9-17-48*

MARGIN RESERVED FOR BINDING

VS A16 9-23-15M

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09798

Reg. Dist. No. 350

## 1. PLACE OF DEATH:

County WorcesterCity or town Pocomoke  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Rural Pocomoke md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2. (a) If veteran, name war World War I

## 3. (a) FULL NAME

John S. Jones

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Viola Mae Jones6. (c) If alive, give age 48 years

7. Birth date of

deceased (mo., day, yr.)

January 20 - 1896

8. AGE:

Years

Months

Days

If less than one day

52 7 17 hrs. min.

9. Birthplace

Pocomoke, Worcester, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

Marion S. Jones

12. Name

13. Birthplace

Md.

14. Maiden name

Vemma Redden

15. Birthplace

Md.16. Informant Mrs Viola Mae JonesAddress Rural Pocomoke md.17. Burial Date there Sept. 10 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baptist CemeteryLocation Pocomoke md.18. Funeral director Henry H. WilsonAddress Pocomoke md.19. Sept. 10 19 48 Anne E. White  
(Date reg'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1948 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him alive on Sept 7th 19 48

Immediate cause of death

Cranial disease DURATION 5K

Due to

Due to

Other conditions

Parasitic infection + died instantly when  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. J. S. Jones M. D. 9/8/48Address Pocomoke md. Date signed \_\_\_\_\_



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SEP 13 1948  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

09799

166

## 1. PLACE OF DEATH:

County Worcester  
City or town Bishop, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Worcester  
City or town Bishop (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Charles Mumford

## 3. (b) Social Security Number

221-16-5042

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.)

Oct. 29, 1924

6. (c) If alive, give age years

8. AGE:

23

Years

10

Months

Days

5

If less than one day

hrs.min.

9. Birthplace

Bishopville, Md.  
(Town, county, and state)

10. Usual occupation

Day Laborer

11. Industry or business

MOTHER FATHER

12. Name

Henry Mumford

13. Birthplace

Sympsonville, Md.

14. Maiden name

Thelma Walters

15. Birthplace

Bishopville, Md.

16. Informant

Henry Mumford

Address

Bishopville, Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

9-8-1948

Cemetery or crematory

Evergreen Cemetery

Location

Berlin, Md.

18. Funeral director

Henry N. Watson

Address

Pocomoke City, Md.

19.

(Date rec'd by registrar)

9-8-48 Helen H. Hayward

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 4th 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...  
and that I last saw him dead Sept 4th 19...  
Immediate cause of death

Due to

Heart wound

Due to

Pistol shot.

Other conditions

Abdominal & Lung wounds

(Include pregnancy within 8 months of death)

Major findings of operations

Wounds through head & front of neck  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Involved at work?

23. SIGNATURE

A. S. Hartman, M.D.

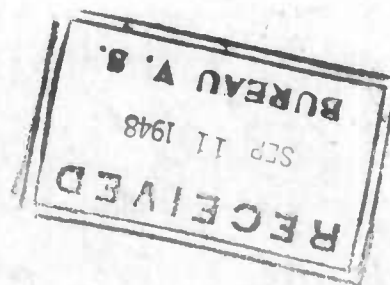
Address

Pocomoke City, Md.

Date signed

9/5/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09800

Reg. Dist. No. 357

1. PLACE OF DEATH: *Worcester*  
 County.....  
 City or town..... *Snow Hill*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *6 mo 28 days*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *Maryland* County *Worcester*  
 City or town..... *Snow Hill*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... *70*

3. (a) FULL NAME *Johnnie Lee Nelson*

3. (b) Social Security Number

*None*

4. Sex *Male* 5. Color or race *Caucasian* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Feb. 4 - 1948* 6. (c) If alive, give age..... years

8. AGE: Years Months Days It less than one day  
*6 28* hrs. min.

9. Birthplace *Snow Hill, Worcester, Md*  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name *Riley J. Nelson*

13. Birthplace *Georgia*

14. Maiden name *Ella M. Wright*

15. Birthplace *Maryland*

16. Informant *Ella M. Nelson*

Address *Snow Hill, Md*

17. *Burial* Date thereof *Sept. 2 / 48*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Bethel*

Location *Snow Hill, Md*

18. Funeral director *Elmer E. Dennis*

Address *Snow Hill, Md*

19. *9/2 48* *Reddy Smith*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *September 2* 19 *48* at *1:15* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *8/31/48* 19 to *9/2/48* 19

and that I last saw him alive on *Sept. 1* 19 *48*

Immediate cause of death *Asphyxia from aspiration of vomitus* DURATION *1 day*

Due to *Castro-enteritis*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

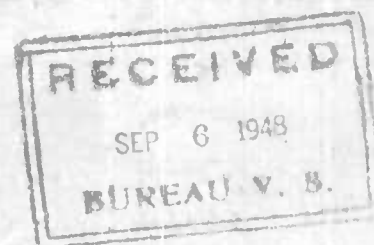
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Paul Chen M.D.*

Address *Snow Hill Md* Date signed *9/2/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County Worcester  
 City or town Berlin Md R1D  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md County Worcester  
 City or town Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Charlotte Ann Powell.

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow  
 6. (b) Name of husband or wife John J. Powell  
 7. Birth date of deceased (mo., day, yr.) July 15, 1870  
 8. AGE: Years 78 Months 2 Days 12 If less than one day  
 hrs. min.

9. Birthplace Berlin Wor Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business

12. Name Wesley Gaulb.  
 13. Birthplace Maryland  
 14. Maiden name Sally Mary Baker  
 15. Birthplace Maryland

16. Informant Miss Mary Warren  
 Address Berlin Md.

17. Buried Date thereof 9/30/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Odd Fellows  
 Location Bristowville Md.

18. Funeral director Benjamin A. Buehner  
 Address Berlin Md.

19. 9-30- 48 Helen F. Hayward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948 10:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 1948 to 1948  
 and that I last saw her alive on Sept 25 1948  
 Immediate cause of death

Coronary  
Arteriosclerosis  
 Due to  
 Due to  
 Other conditions Chronic Nephritis  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Chas R. Low MD  
 M. D. or other  
 Address Berlin Md Date signed 9-18-48

APR 21 1948

APR 22 1948

Carrying Case

Old papers

RECEIVED  
OCT 5 1948  
BUREAU V. S.

John R. Forman  
1948



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **353**

### 1. PLACE OF DEATH:

County Worcester  
City or town Ocean City, Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Ma. County Worcester  
City or town Ocean City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R. D. Berlin, Md.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Julia E. Powell

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Isaac Powell

7. Birth date of deceased (mo., day, yr.) Jan 26, 1850 8. (c) If alive, give age years

8. AGE: Years 98 Months 8 Days 2 If less than one day hrs. min.

9. Birthplace Del. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James Breasure

13. Birthplace Del.

14. Maiden name E. Elizabeth Rogers

15. Birthplace Del.

16. Informant Mrs. E. Elizabeth McLaughlin

Address Berlin, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Sept 30, 1948 (month) (day) (year)

Cemetery or crematory Bethel Cemetery

Location Ocean View Del.

18. Funeral director Henry H. Watson

Address Pocomoke, Md.

19. Sept 29, 1948 Hilda R. Bury Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1948, at 5:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948 to Sept 1948

and that I last saw her alive on Sept 27 1948.

Immediate cause of death Respiratory failure ? DURATION

4 mos.

Due to Congestive heart failure

4 mos.

Due to Arterio-sclerotic cardio-vascular disease

years.

Other conditions Advanced age

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE H. Watson, Jr. M.D.

Address Ocean City, Md. Date signed Sept 29, 1948

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

OCT 4 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No.

09803

355

## 1. PLACE OF DEATH:

County Worcester  
 City or town Bishops Shoewell  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Worcester  
 City or town Shoewell  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret Taylor Zuelten

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Thomas J. Zuelten  
 6. (c) If alive, give age 21 years  
 7. Birth date of deceased (mo., day, yr.) Sept. 15, 1871  
 8. AGE: Years 77 Months 09 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Newark Wm Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife

## 11. Industry or business

12. Name Joseph Henry Taylor  
 13. Birthplace Md.  
 14. Maiden name Cordelia Harmon  
 15. Birthplace Md.

16. Informant Mr. Thomas J. Zuelten  
 Address Bishops Shoewell

17. burial Date thereof 10/3/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Evergreen  
 Location Berlin Md.

18. Funeral director Dr. A. B. B. B.  
 Address Berlin Md.

19. 10-2-48 Helen F. Hayward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1948 at 2 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw her alive on Sept 29 1948  
 Immediate cause of death \_\_\_\_\_  
 DURATION \_\_\_\_\_

Due to Cerebral  
Hemorrhage.  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

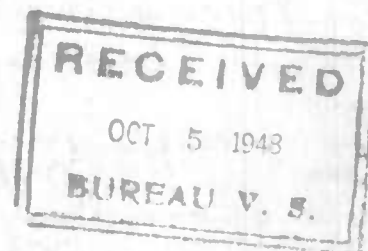
23. SIGNATURE Chas. R. Law Md  
 M. D. or other \_\_\_\_\_  
 Address Berlin Md. Date signed 9.30.48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and project age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09804

Reg. Dist. No. 350

## 1. PLACE OF DEATH:

County Worcester  
 City or town Dorchester City  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 39 years  
 Hospital, institution, or street address where death occurred: L  
 How long in hospital or institution? L

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Worcester  
 City or town Dorchester Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 601 South Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war L

## 3. (a) FULL NAME

Daniel W. Shaw Sr.

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Louise Shaw

## 6. (c) If alive, give age

78 years

## 7. Birth date of deceased (mo., day, yr.)

May 22-1867

## 8. AGE:

Years

81

## Months

4

## Days

5

## It less than one day

L hrs. L min.

## 9. Birthplace

Philadelphia Penna.  
(Town, county, and state)

## 10. Usual occupation

Barber

## 11. Industry or business

L

## FATHER

## 12. Name

D. W. Shaw Sr.

## 13. Birthplace

Penna.

## MOTHER

## 14. Maiden name

Mary W. Shyman

## 15. Birthplace

Maryland

## 16. Informant

D. W. Shaw Jr.

## Address

Dorchester City Md.

## 17.

Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Sept 29 1948

(month)

(day)

(year)

## Cemetery or crematory

Presbyterian Cemetery

## Location

Dorchester City Md.

## 18. Funeral director

Sherry McChesin

## Address

Dorchester Md.

## 19.

Sept 29 1948

(Date rec'd by registrar)

Anne E. White

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1948 at 4:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1948 to Sept 27 1948and that I last saw him alive on Sept 27 1948Immediate cause of death Cerebral EmbolusDue to Hypertension, Arterio-sclerosis, DiabetesDue to LOther conditions L

(Include pregnancy within 3 months of death)

Major findings of operations LAutopsy results L

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide L Date of L

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury L Injured at work?23. SIGNATURE Louis S. Cleveland MDAddress Dorchester City Md. Date signed 9/27/48

RECEIVED

OCT 1 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09805

Reg. Dist. No. 855

## 1. PLACE OF DEATH:

County Worcester  
 City or town Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 70 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Worcester  
 City or town Berlin  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Daniel Henry Shrockley

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widower  
 6.(b) Name of husband or wife Emma Scott Shrockley  
 7. Birth date of deceased (mo., day, yr.) April 7, 1863 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 85 Months 5 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Poundville Wisconsin & Md.  
 (Town, county, and state)  
 10. Usual occupation Retired Farmer  
 11. Industry or business \_\_\_\_\_

12. Name Daniel H. Shrockley Jr  
 13. Birthplace Maryland  
 14. Maiden name Ellen Dennis  
 15. Birthplace Maryland  
 16. Informant Mr. John Shrockley  
 Address Berlin Md  
 17. Burial Date thereof 10/1/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Evergreen  
 Location Berlin Md  
 18. Funeral director Dana R. Burdige  
 Address Berlin Md  
 19. 10-1- 1948 Helen F. Hayward  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29- 1948 at 9 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
 Immediate cause of death \_\_\_\_\_

Acute Dilated  
Heart  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Chr Myocarditis  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_  
 \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Chas. R. Law  
SPR 28 Berlin M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 9-30-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

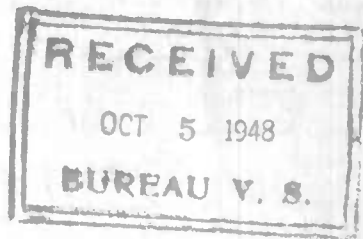
VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AP 74 10 11

Robert B. ...  
Hart

...



...



PLEASE WRITE PLAINLY IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 355

## 1. PLACE OF DEATH:

County Worcester  
 City or town RURAL TAYLORSVILLE  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 mos.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State DELAWARE County NEW CASTLE  
 City or town WILMINGTON  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 600 S. VAN BUREN ST.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JAN TOMCZYK  
 4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED  
 6. (b) Name of husband or wife ALEXANDRA  
 7. Birth date of deceased (mo., day, yr.) DEC. 22, 1880  
 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 67 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Sep 19 48 at 46 M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 48 to 7 Sep 19 48  
 and that I last saw h. i. m. alive on 6 Sep 19 48  
 Immediate cause of death Asphyxiation Pneumonia

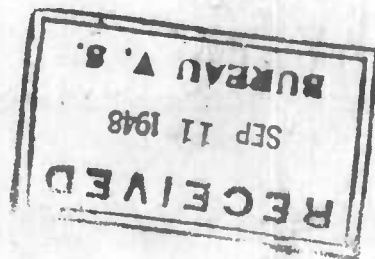
Due to Emphysema & Core arteriosclerosis bronchitis 5 yrs.  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Hermanus Radlauer M. D. or other \_\_\_\_\_  
 Address 5 Bay St. Beulah, Mo. Date signed 5 Sep 48

9. Birthplace POLANO (Town, county, and state)  
 10. Usual occupation RETIRED LABORER  
 11. Industry or business SHIPYARD-POSEYIONS CORP.  
 12. Name NO RECORD  
 13. Birthplace NO RECORD  
 14. Maiden name NO RECORD  
 15. Birthplace \_\_\_\_\_  
 16. Informant MRS. HELEN LYNCH  
 Address TAYLORSVILLE MD  
 17. BURIAL Date thereof 9/10/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory CATHEDRAL CEM.  
 Location WILMINGTON DEL  
 18. Funeral director EDWARD FENOWS  
 Address WILMINGTON MD  
 19. 9-9- 48 Helen F. Hayward Registrar  
 (Date rec'd by registrar)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

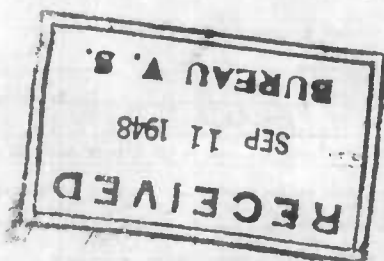
## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

|  |   |   |                          |
|--|---|---|--------------------------|
| <b>1. PLACE OF DEATH:</b><br>County..... <u>Worcester</u><br>City or town..... <u>Pocomoke City</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>How long in above place of death?.....<br>Hospital, institution, or street address where death occurred:<br><u>408 Market St.</u><br>How long in hospital or institution?..... |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b><br>(For newborn infants give residence of mother)<br>State..... <u>Maryland</u> County..... <u>Worcester</u><br>City or town..... <u>Pocomoke City</u><br>(If outside city or town limits, write RURAL and give nearest town)<br>Street No..... <u>408 Market St.</u><br>(If rural, give LOCATION)<br>2.(a) If veteran, name war..... |                          |
| <b>3. (a) FULL NAME</b><br><u>Margaret J. Townsend</u>   |   | <b>3. (b) Social Security Number</b>  |                          |
| <b>4. Sex</b><br><u>Female</u>   | <b>5. Color or race</b><br><u>White</u> | <b>6. (a) Single, married, widowed, or divorced</b><br><u>Widow</u>   |                          |
| <b>6. (b) Name of husband or wife</b> <u>John F. Townsend</u>  |   |   |                          |
| <b>6. (c) If alive, give age</b> ..... years   |   |   |                          |
| <b>7. Birth date of deceased (mo., day, yr.)</b> <u>June 15, 1877</u>  |   |   |                          |
| <b>8. AGE:</b><br><u>71</u>  | <b>Years</b><br><u>2</u>                | <b>Months</b><br><u>22</u>  | <b>Days</b><br><u>22</u> |
| <b>It less than one day</b><br>..... hrs. .... min.  |   |   |                          |
| <b>9. Birthplace</b> <u>Somerset County, Maryland</u><br>(Town, county, and state)   |   |   |                          |
| <b>10. Usual occupation</b> <u>House Wife</u>  |   |   |                          |
| <b>11. Industry or business</b>  |   |   |                          |
| <b>12. Name</b> <u>William Elliott</u>   |   |   |                          |
| <b>13. Birthplace</b> <u>Somerset County, Maryland</u>   |   |   |                          |
| <b>14. Maiden name</b> <u>?</u>  |   |   |                          |
| <b>15. Birthplace</b> <u>?</u>   |   |   |                          |
| <b>16. Informant</b> <u>Mrs Myrtle A. Ennis</u><br>Address <u>Pocomoke City, Maryland</u>  |   |   |                          |
| <b>17. Burial</b> <u>8/10/1948</u><br>(Burial, cremation, or removal. Which?) (month) (day) (year)<br>Cemetery or crematory..... <u>Oak Lawn</u><br>Location..... <u>Eastern Ave, Baltimore, Maryland</u>  |   |   |                          |
| <b>18. Funeral director</b> <u>Howard A. Gill</u><br>Address <u>Pocomoke City, Maryland</u>  |   |   |                          |
| <b>19. Date rec'd by registrar</b> <u>Sept 9, 1948</u> <u>Anne E. White</u><br>Registrar   |   |   |                          |
| <b>MEDICAL CERTIFICATION</b>   |   |   |                          |
| <b>20. DATE OF DEATH</b> <u>Sept, 6, 1948</u> at <u>11:30</u> P.M.   |   |   |                          |
| <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>1946</u> to <u>Sept 6, 1948</u> and that I last saw her alive on <u>Sept 6, 1948</u>   |   |   |                          |
| <b>Immediate cause of death</b> <u>Cerebral Thrombosis</u><br><u>&amp; Hemiplegia</u><br><b>Due to</b> <u>Mitral Stenosis.</u><br><b>Due to</b> <u>Hypertension</u>  |   |   |                          |
| <b>Other conditions</b> .....<br>(Include pregnancy within 8 months of death)  |   |   |                          |
| <b>Major findings of operations</b> .....<br>Date of op. ....  |   |   |                          |
| <b>Autopsy results</b> <u>None</u><br><b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.   |   |   |                          |
| <b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:<br>Accident, suicide, or homicide..... Date of.....<br>Where did injury occur?..... (City or town) (County) (State)<br>Injured at home, farm, industry, public place (where?).....<br>Means of injury..... Injured at work?.....  |   |   |                          |
| <b>23. SIGNATURE</b> <u>Louis J. Flewchman, M.D.</u><br>Address <u>Pocomoke City</u> Date signed <u>9/9/48</u>   |   |   |                          |



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09808

Reg. Dist. No. 350

### 1. PLACE OF DEATH:

County Accomack  
City or town Rural Accomack  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution? ✓

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Worcester  
City or town Accomack Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

### 3. (a) FULL NAME

Henry West

### 3. (b) Social Security Number

170-12-2225

4. Sex M 5. Color or race col 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Maggie Rogers West  
May 8, 1888 6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec. 1882

8. AGE: Years 66 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Accomack Co. Va.  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business saw mill

12. Name Donk Know

13. Birthplace Rose Bailey

14. Maiden name Accomack Co. Va.

15. Birthplace Beatrice O. Poulson

16. Informant Melba Va

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof September 16, 1948  
(month) (day) (year)

Cemetery or crematory Cemetery

Location Shiloh, Boston Virginia

18. Funeral director Alfred H. Ames

Address Melba Virginia

19. Sept. 15, 1948 Anne E. White  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1948 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to Sept 13 1948  
and that I last saw him alive on Sept 13 1948

Immediate cause of death apoplexy

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. L. L. L. L. M. D. or other \_\_\_\_\_

Address Green Church Date signed Sept 15, 1948

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 17 1948  
BUREAU A. S.